'First do no harm'—a clear line in law and medical ethics

We have a bill before Parliament that would fundamentally change the way doctors practice medicine and the way that those with distress are managed. Lord Joffe's Assisted Dying for the Terminally Ill bill (ADTI) is designed to enable an adult who has capacity and who is suffering unbearably as a result of a terminal illness to receive medical assistance to die at his own considered and persistent request. At first sight this seems a compassionate and laudable aim, so why would anyone object?

The problems lie in the very nature of the bill itself, and in the reason it is presented as it is. This is the third such bill Lord Joffe has laid before Parliament in as many years. The previous version was the subject of a lengthy select committee inquiry whose report is a comprehensive and up-to-date overview on the topic of physician assisted suicide/euthanasia. The select committee made a number of important recommendations to produce better safeguards in any future bill, which might be presented; but the proponents of the latest bill have chosen to ignore almost all of these, claiming there are stringent safeguards in the new bill and that it is modelled on Oregon's Death with Dignity Act (ODDA).

However, unlike the ODDA, this bill would authorize doctors not only to prescribe lethal drugs but also, in 'appropriate' cases, to set up an intravenous line, with the patient being required simply to trigger the release of drugs into his or her vein, taking us to the very edge of euthanasia. The select committee recommended that the doctor's duties must be clear; yet ADTI is inexplicit about actions that would be lawful for a doctor to take (it talks only of 'assisting the patient to die'), posing problems for doctors as to whether they were operating within the law or crossing the line.

So what are the so-called safeguards? They restrict assisted suicide to adult patients who are terminally ill, who do not 'lack capacity' and who are 'suffering unbearably'. The require assessment of all applicants by two doctors, they require that an applicant is offered a consultation on palliative care and they require two witnesses to a declaration. There is also a 'conscience clause' to enable doctors and others to opt out of taking part in the process.

It may sound reasonable enough. But how will such safeguards work in practice? How will those doctors, nurses, pharmacists, clerical staff who conscientiously object really avoid dealing with those seeking assistance to commit suicide? What will be the effect on other patients in a ward who overhear such discussions? And how impartial will be a second opinion? Or will we seek one from someone whose views are likely to concur with our own?

The select committee heard evidence that accurate prognosis is not possible beyond 8–12 weeks; so it recommended that terminal illness 'should be defined in such a way as to reflect the realities of clinical practice'.[2] Yet the bill ignores this, with its arbitrary requirement that death is predicted '. . . within six months'; even Anne Turner, who recently committed suicide in Switzerland, fell well outside that requirement.

The bill requires that the patient must be 'suffering unbearably'; but who can objectively assess how bearable or unbearable suffering is? Only the patient can answer this question, and Lord Joffe himself admitted to the select committee that it could be no more than the patient's own opinion. So this is no more than a token safeguard.[3] Because of concerns such as these, the select committee recommended that 'unrelievable' suffering would be a more objective test,[4] but this has been ignored.

Proponents have argued that ADTI would comfort those facing death, but others have highlighted the new decision this treatment option brings. Anyone within an expected 6 months of death would be faced with this enduring choice: whether they should 'go for' assisted suicide, feeling they have become a burden, and fearful of tomorrow being worse than today.[5] And how could such coercion, real or perceived, be detected?

The bill seems confused as to whether its main objective is terminal illness or suffering. Terrible suffering exists outside terminal illness and is arguably greater when it has to be endured for years. The insertion of a condition on suffering opens the door to future extensions beyond terminal illness; as Lord Joffe himself said, he wanted his last bill '. . . to be of much wider application' and would welcome an extension to include those patients who were younger and who were not terminally ill but who were 'suffering unbearably'.[6]

After performing euthanasia, 42% of Dutch doctors report feelings of discomfort, and 43% later sought support in coping—usually from family, friends or colleagues.[7] The process is not without complications: the attending physician found it necessary to intervene by administering a lethal drug in 18% of Dutch physician assisted suicides.[8] And the Dutch experience suggests such a cultural change occurs, with euthanasia deaths (at 1 in 32 of all deaths) now accounting for six times their road accident death rate.

In The Netherlands only about 54 % of euthanasias are officially reported.[9] No such study has been done in Oregon; but Oregon has no tracking system to detect illegal prescriptions for barbiturates—the drug used for physician assisted suicide—so the incidence of PAS could be much higher than official figures suggest. By contrast, in the UK recent data show no evidence of physician assisted suicide

and indicate that any covert euthanasia is much less frequent than in other countries—and especially those which have legalized 'assisted dying'—probably because palliative care has influenced decision-making for the good.[10]

For centuries medicine has depended on the age-old principle of 'First do no harm'. The law of the land mirrors medical ethics exactly here. A patient is free to refuse life-sustaining treatment—that is not suicide. Ineffective treatments can be discontinued: we do not have to keep our patients alive at all costs. But we must not deliberately and intentionally end or help to end a patient's life.

This rule of both medical ethics and law has been described as a 'bright line'—a line which is not invariably observed by doctors any more than by others, but a line, nonetheless, which is not in the least ambiguous. But, if Lord Joffe's bill succeeds, it will become a blurred line, as doctors would become the gatekeepers on assisting patients to commit suicide. They would have to make subjective—and in many cases non-clinical—judgements about such things as whether a patient who asks for lethal drugs is of sound mind, or is free from internal or external coercion, or has suffering which is 'unbearable'. After 'do no harm', it would be necessary to add the word 'unless . . . '.

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REFERENCES

1 Gilbert J. *HL Paper 86-II, Page 552 (session 2004–05).* London: Stationery Office, 2005

2 *HL Paper 86-I, Paragraph 269*. London: Stationery Office, 2005

3 *HL Paper 86-II, Page 49*. London: Stationery Office, 2005

4 *HL Paper 86-I, Paragraphs 255–256*. London: Stationery Office, 2005

5 Randall F. *HL Paper 86-II, page 554–7*. London: Stationery Office, 2005

6 Lord Joffe. *HL Paper 86-I, Paragraph 92*. London: Stationery Office, 2005

7 Haverkate I, van der Heide A, Onwuteaka-Philipsen BD, van der Maas PJ, van der Wal G. The emotional impact on physicians of hastening the death of a patient *Med J Aust* 2001;**175**:519–22

8 Groenewoud JH, van der Heide A, Onwuteaka-Philipsen BD, Willems DL, van der Maas PJ, van der Wal G. Clinical problems with the performance of euthanasia and physician-assisted suicide in the Netherlands. *N Engl J Med* 2000;**342**:551–6

9 Sheldon T. Only half of Dutch doctors report euthanasia. *BMJ* 2003; **326**:1164

10 Seale C. National Survey of End-of-Life Decisions made by UK Medical Practitioners. *Palliat Med* 2006;**20**:3–10

Self-image in obesity: clinical and public health implications

'I know that I am more than my personality, my body, and my body image'. Oprah Winfrey

No-one can be in any doubt that a global epidemic of obesity in adults[1] and children[2] is well and truly upon us. According to current estimates more than 1 billion adults are overweight, with over 3 million who are obese.[1] These figures are based on body mass index (BMI), a relatively imprecise measure of body fat, calculated as weight divided by the square of height, measured in population samples. The World Health Organization [http://www.who.int] classifies overweight as a BMI >25 kg/m^2 with obesity being a BMI >30 kg/m^2. This classification reflects a dose-effect relationship between increasing adiposity and adverse clinical outcomes.

The threats to health associated with obesity stem principally from the development of adverse metabolic profiles and an excess of certain cancers. In fact, the risks of metabolic complications including diabetes, dyslipidaemia and hypertension start to increase at lower levels of BMI. This risk varies with ethnicity and, for this reason a lower level of BMI, 23 kg/m^2 is now regarded as more appropriate threshold for South and East Asian populations. Having said this, there is a growing view that waist circumference, a surrogate of visceral adiposity, may be a more sensitive indicator of some forms of risk.[1] For Asians, levels of waist girth denoting an increased risk of diabetes and cardiovascular disease are lower than for White Europeans; this view is incorporated into the new International Diabetes Federation [http://www.idf.org] definition of the metabolic syndrome. Inconsistencies between different studies and variations in methodology provide continuing uncertainty about the best means for quantifying health risks associated with overweight and obesity. For example, in a recent large international case–control study, waist-to-hip ratio was a better predictor than BMI of myocardial infarction.[3]

Assessments of the societal burden of disease attributable to obesity relying on data from population samples carry a potential for error. This may be compartmentalized into random error and, in studies based on self-reported information, systematic reporting bias. It has long been recognized that people tend to think that they are taller than they really are (men especially) and somewhat slimmer than the bathroom scales would tell them. This, of course, is no surprise and world-weary clinicians tend to take a somewhat sceptical view of self-reported smoking habits,